

114.2 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
LONG-TERM CARE FACILITIES

6.05: continued

2. The Division will calculate Allowable Fixed Costs *per diem* by dividing Allowable Fixed Costs by the Constructed Bed Capacity times the days in the Rate Year times the greater of 96% or the Actual Utilization Rate in the Rate Year. For the first twelve months of operation, Allowable Fixed Costs will be divided by the greater of actual Patient Days or 96% of Maximum Available Bed Days.
- (d) Equity and Use and Occupancy Allowance. The Division will include a return on Average Equity Capital for Proprietary Providers. The Division will include a Use and Occupancy Allowance for certain Non-Profit Providers.
 1. Average Equity Capital. Average Equity Capital is the average of the difference between the Provider's Allowable Basis of Fixed Assets as determined under 114.2 CMR 6.05(2)(a), and the Provider's allowable long-term liabilities at the beginning and end of the year. For equity, allowable long-term liabilities are total allowable debt supported by total allowable assets, including land.
 - a. The Division will reduce Average Equity Capital by depreciation allowed on the Building, Improvements, Equipment and software.
 - b. The Division will not include Mortgage Acquisition Costs, such as capitalized legal fees and prepaid interest on long-term obligations, or equity in Buildings and/or Equipment not located at the Nursing Facility, in Average Equity Capital.
 - c. The Division will not reduce Average Equity Capital by long-term loans for which interest has been excluded.
 - d. If a facility replaces beds, reimbursable equity will be recalculated using the newly established allowable fixed assets and allowable debt, exclusive of equity supplement, if any, which was previously granted pursuant to 114.2 CMR 5.00 for the structure to be replaced by the new construction.
 - e. Calculation of Average Equity Capital Allowance. The average equity capital allowance is calculated by multiplying Average Equity Capital by 7.875%.
 - f. The Division will calculate allowable Average Equity Capital *per diem* by dividing the Average Equity Capital Allowance by the current Licensed Bed Capacity, including Resident Care Units, times the days in the Rate Year, times the greater of 96% or the Actual Utilization Rate.
 2. Use and Occupancy Allowance for Non-Profit Providers.
 - a. The Division will include a Use and Occupancy Allowance in the rates of Non-Profit Providers that have maintained a public occupancy rate, including Medicaid, Massachusetts Commission of the Blind, and Medicare Patient Days, of at least 70%.
 - b. The Division will calculate the Use and Occupancy Allowance by using the methodology set forth in 114.2 CMR 6.05(2)(d)1.e. and dividing the result by three.
 - c. The Division will calculate an allowable Use and Occupancy *per diem* by dividing the Use and Occupancy Allowance by the current Licensed Bed Capacity for the Rate Year, including Resident Care Units, times the days in the Rate Year, times the greater of 96% or the Actual Utilization Rate.
- (e) Payment for Capital Costs.
 1. The Division will calculate the sum of the facility's:
 - a. Allowable Fixed Costs pursuant to 114.2 CMR 6.05(2)(c), and
 - b. Equity or Use and Occupancy Allowance, pursuant to 114.2 CMR 6.05(2)(d).
 2. If the calculated amount in 114.2 CMR 6.05(2)(e)1. is lower than \$17.29, Payment for Capital Costs will equal the calculated amount. If the calculated amount exceeds \$17.29, Payment for Capital Costs will equal the greater of 90% of the calculated amount or \$17.29. Payment under this section applies to:
 - a. New Facilities and newly-licensed beds which open pursuant to a Determination of Need approved before March 7, 1996,
 - b. renovations pursuant to a Determination of Need approved before March 7, 1996,
 - c. facilities which requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4), and
 - d. facilities that implement a transferred Determination of Need approved before March 7, 1996 and that filed a Notice of Intent to Acquire before March 7, 1996.
 3. Payment for Capital Costs will equal the lower of the calculated amount or \$17.29 for the following:

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- a. facilities which renovate pursuant to a Determination of Need approved after March 7, 1996, and
 - b. facilities that implement a transferred Determination of Need approved before March 7, 1996 but did not file a Notice of Intent to Acquire the facility before March 7, 1996. This provision will not apply if the transfer occurred on or after February 1, 1998 and before May 30, 1998. If the transfer occurred during this period, Payment for Capital Costs will be determined under 114.2 CMR 6.05(2)(e)2.
- (3) Notification Process. All facilities must notify the Division and file a submission when they open, add new beds, renovate or re-open beds.
- (a) General Notification Requirements. All facilities must submit the following information:
 1. the Provider's name, address and VPN;
 2. a detailed explanation of the basis for the requested rate or rate adjustment;
 - (b) Submission for Rate Year Adjustments. A facility requesting a Rate Year Adjustment under 114.2 CMR 6.05(2) must also include the following information:
 1. a copy of the construction contract;
 2. copies of invoices and cancelled checks for construction costs;
 3. a copy of the mortgage documents;
 4. a copy of the Department's licensure notification associated with the new beds; and,
 5. any other information the Division determines necessary to calculate a new rate or rate adjustment.
 - (c) Effective Date. A facility requesting a new rate or Rate Year Adjustment must file its submission with the Division during the rate year. The effective date of the new or adjusted rate will be the later of the date of the filing or the date on which the event occurred.

6.06: Reporting Requirements

- (1) Required Cost Reports.
 - (a) Nursing Facility Cost Report. Each Provider must complete and file a Nursing Facility Cost Report each calendar year. The Nursing Facility Cost Report must contain the complete financial condition of the Provider, including all applicable management company, central office, and real estate expenses.
 - (b) Realty Company Cost Report. A Provider that does not own the real property of the nursing facility and pays rent to an affiliated or non-affiliated realty trust or other business entity must file or cause to be filed a Realty Company Cost Report.
 - (c) Management Company Cost Report. A Provider must file a separate Management Company Cost Report for each entity for which it reports management or central office expenses related to the care of Massachusetts publicly-aided residents. If the Provider identifies such costs, the Provider must certify that costs are reasonable and necessary for the care of Publicly-Aided Residents in Massachusetts.
- (2) General Cost Reporting Requirements.
 - (a) Accrual Method. Providers must complete all required reports using the accrual method of accounting.
 - (b) Documentation of Reported Costs. Providers must maintain accurate, detailed and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of any appeal of a rate for the period covered by the report, whichever is later. Providers must maintain complete documentation of all of the financial transactions and census activity of the Provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the Provider's reported costs. Providers must be able to document expenses relating to affiliated entities for which it has identified costs related to the care of Massachusetts publicly-aided residents whether or not they are Related Parties.
 - (c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger which clearly identifies each asset for which expenses are reported, including location, date of purchase, cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.

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6.06: continued

(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including qualifications, duties, responsibilities, and time records such as time cards for all positions which the Provider identifies as related to the care of Massachusetts publicly-aided residents. Facilities organized as sole proprietors or partnerships in which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits must maintain documentation to support the provision of administrator services by the sole proprietor or partner.

(e) Other Cost Reporting Requirements.

1. Administrative Costs.

a. The following expenses must be reported as administrative:

i. All compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the Nursing Facility;

ii. Expenses related to tasks performed by persons at a management level above that of an on-site Provider department head, which are associated with monitoring, supervising, and/or directing services provided to residents in a Nursing Facility as well as legal, accounting, financial and managerial services or advice including computer services and payroll processing; and

iii. Expenses related to policy-making, planning and decision-making activities necessary for the general and Long-Term management of the affairs of a Nursing Facility, including but not limited to the following: the financial management of the Provider, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of resident admission policies and the planning of the expansion and financing of the Provider.

b. Providers must report the cost of administrative personnel to the appropriate account. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries or other compensation.

c. Providers may allocate administrative costs among two or more accounts. The Provider must maintain specific and detailed time records to support the allocation.

2. Draw Accounts. Providers may not report or claim proprietorship or partnership drawings as salary expense.

3. Expenses which Generate Income. Providers must identify the expense accounts which generate income.

4. Fixed Costs.

a. Additions. If the square footage of the Building is enlarged, Providers must report all additions and renovations as Building Additions.

b. Allocation. Providers must allocate all fixed costs, except Equipment, on the basis of square footage. A Provider may elect to specifically identify Equipment related to the Nursing Facility. The Provider must document each piece of Equipment in the fixed asset ledger. If a Provider elects not to identify Equipment, it must allocate Equipment on the basis of square footage.

c. Replacement of Beds. If a Provider undertakes construction to replace beds, it must write off the fixed assets which are no longer used to provide care to Publicly-Aided Residents and may not identify associated expenses as related to the care of Massachusetts publicly-aided residents.

d. Fully Depreciated Assets. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all Cost Reports unless they have removed such costs and accumulated depreciation from the Provider's books and records. Providers must attach a schedule of the cost of the retired Equipment, accumulated depreciation, and the accounting entries on the books and records of the Provider to the Cost Report when Equipment is retired.

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- e. Providers must report all expenditures for major repair projects whose useful life is greater than one year, including, but not limited to, wallpapering and painting as Improvements. Providers may not report such expenditures as prepaid expenses.
 - 5. Laundry Expense. Providers must separately identify the expense associated with laundry services for which non-Publicly-Aided Residents are billed. Providers must identify such expense as non-related to Medicaid patient care.
 - 6. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as Other Assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.
 - 7. Nursing Costs. The costs must be associated with direct resident care personnel and be required to meet federal and state laws.
 - 8. Related Parties. Providers must disclose salary expense paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Provider purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services.
- (3) Special Cost Reporting Requirements.
- (a) Facilities in which other programs are operated. If a Provider operates an adult day health program, an assisted living program, or provides outpatient services, the Provider may not identify expenses of such programs as related to the care of Massachusetts publicly-aided Residents.
 - 1. If the Provider converts a portion of the Provider to another program, the Provider must identify the existing Equipment no longer used in Nursing Provider operations and remove such Equipment from the Nursing Provider records.
 - 2. The Provider must identify the total square footage of the existing Building, the square footage associated with the program, and the Equipment associated with the program.
 - 3. The Provider must allocate all shared costs, including shared capital costs, using a well-documented and generally accepted allocation method. The Provider must directly assign to the program any additional capital expenditures associated with the program.
 - (b) Hospital-Based Nursing Facilities. A Hospital-Based Nursing Provider must file Cost Reports on a fiscal year basis consistent with the fiscal year used in the DHCFF-403 Hospital Cost Report. The Provider must:
 - 1. identify the existing Building and Improvement costs associated with the Nursing Provider. The Provider must allocate such costs on a square footage basis.
 - 2. report major moveable Equipment and fixed Equipment in a manner consistent with the Hospital Cost Report. In addition, the Provider must classify fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 114.2 CMR 6.02. The Provider may elect to report major moveable and fixed Equipment by one of two methods:
 - a. A Provider may elect to specifically identify the major moveable and fixed Equipment directly related to the care of Publicly-Aided Residents in the Nursing Provider. The Provider must maintain complete documentation in a fixed asset ledger, which clearly identifies each piece of Equipment and its cost, date of purchase, and accumulated depreciation. The Provider must submit this documentation to the Division with its first budgeted Nursing Provider Cost Report.
 - b. If the Provider elects not to identify specifically each item of major moveable and fixed Equipment, the Division will allocate fixed Equipment on a square footage basis.
 - 3. The Provider must report additional capital expenditures directly related to the establishment of the Nursing Provider within the hospital as Additions. The Division will allocate capital expenditures which relate to the total plant on a square footage basis.
 - 4. The Provider must use direct costing whenever possible to obtain operating expenses associated with the Nursing Provider. The Provider must allocate all costs shared by the hospital and the Nursing Provider using the statistics specified in the Hospital Cost Report instructions. The Provider must disclose all analysis, allocations and statistics utilized in preparing the Nursing Provider Cost Report.

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(4) General Cost Principles. In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria:

- (a) The cost must be ordinary, necessary and directly related to the care of Publicly-Aided Residents;
- (b) The cost must be for goods or services actually provided in the nursing facility; and
- (c) The cost must be reasonable; and
- (d) The cost must actually be paid by the Provider. Costs which are not considered related to the care of Massachusetts publicly-aided Residents include, but are not limited to: costs which are discharged in bankruptcy; costs which are forgiven; costs which are converted to a promissory note; and accruals of self-insured costs which are based on actuarial estimates;
- (e) A provider may not report the following costs as related to the care of Massachusetts publicly-aided Residents:
 1. Bad debts, refunds, charity and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;
 2. Federal and state income taxes, except the non-income related portion of the Massachusetts Corporate Excise Tax;
 3. Expenses that are not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel and expenses related to grants of contracts for special projects;
 4. Compensation and fringe benefits of residents on a Provider's payroll;
 5. Penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;
 6. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;
 7. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies that are not registered with the Department under regulation 105 CMR 157.000;
 8. Any expense or amortization of a capitalized cost which relates to costs or expenses incurred prior to the opening of the facility;
 9. All legal expenses; and those accounting expenses and filing fees associated with any appeal process.

(5) Filing Deadlines.

(a) General. Except as provided below, Providers must file required Cost Reports for the calendar year by 5:00 P.M. of April 1 of the following calendar year. If April 1 falls on a weekend or holiday, the reports are due by 5:00 P.M. of the following business day.

1. Change of Ownership. The transferor must file Cost Reports within 60 days after a Change of Ownership. The Division will notify the Division of Medical Assistance if required reports are not timely filed for appropriate action by that agency.
2. New Facilities and Facilities with Major Additions. New Facilities and facilities with Major Additions that become operational during the Rate Year must file year end Cost Reports within 60 days after the close of the first two calendar years of operation.
3. Hospital-Based Nursing Facilities. Hospital-Based Nursing Facilities must file Cost Reports no later than 90 days after the close of the hospital's fiscal year.
4. Termination of Provider Contract. If a Provider contract between the Provider and the Division of Medical Assistance is terminated, the Provider must file Cost Reports covering the current reporting period or portion thereof covered by the contract within 60 days of termination.
5. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, § 72N, the Provider must file Cost Reports for the current reporting period or portion thereof, within 60 of the receiver's appointment.

(b) Extension of Filing Date. The Director of the ACE Group may grant a request for an extension of the filing due date for a maximum of 45 calendar days. In order to receive an extension, the Provider must:

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1. submit the request itself, and not by agent or other representative;
2. demonstrate exceptional circumstances which prevent the Provider from meeting the deadline; and
3. file the request no later than 30 calendar days before the due date.

(6) Incomplete Submissions. If the Cost Reports are incomplete, the Division will notify the Provider in writing within 120 days of receipt. The Division will specify the additional information which the Provider must submit to complete the Cost Reports. The Provider must file the required information within 25 days of the date of notification or by April 1 of the year the Cost Reports are filed, whichever is later. If the Division fails to notify the Provider within the 120-day period, the Cost Reports will be considered complete and will be deemed to be filed on the date of receipt.

(7) Audits. The Division and the Division of Medical Assistance may conduct Desk Audits or Field Audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any Related Party as requested during a Desk or Field Audit even if the Division has accepted the Provider's Cost Reports.

(8) Penalties for Late Filing of Cost Reports.

(a) If a Provider does not file the required Cost Reports by the due date, the Division will reduce the Provider's rates for current services by 5% on the day following the date the submission is due and 5% for each month of non-compliance thereafter. The reduction accrues cumulatively such that the rate reduction equals 5% for the first month late, 10% for the second month late and so on. The rate will be restored effective on the date the Cost Report is filed.

(b) If a Provider has not filed its Cost Report by six months after the due date, the Division will notify the Provider 30 days in advance that it may terminate the Provider's rates for current services. The Division will rescind termination on the date that the Provider files the required report.

6.07: Special Provisions

(1) Rate Filings. The Division will file certified rates of payment for Nursing Facilities with the Secretary of the Commonwealth.

(2) Appeals. A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after the Division files the rate with the State Secretary. The Division may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal.

(3) Information Bulletins. The Division may issue administrative information bulletins to clarify provisions of 114.2 CMR 6.00 which shall be deemed to be incorporated in the provisions of 114.2 CMR 6.00. The Division will file the bulletins with the State Secretary, distribute copies to Providers, and make the bulletins accessible to the public at the Division's offices during regular business hours.

(4) Severability. The provisions of 114.2 CMR 6.00 are severable. If any provision of 114.2 CMR 6.00 or the application of any provision of 114.2 CMR 6.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 114.2 CMR 6.00 or the application of any other provision.

REGULATORY AUTHORITY

114.2 CMR 6.00: M.G.L. c. 118G.

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APPENDIX B
CASEMIX MANAGEMENT MINUTES CATEGORIES

MANAGEMENT MINUTES CATEGORIES	RANGE OF MINUTES
H	0 - 65
J	65.1 - 85.0
K	85.1 - 110.0
L	110.1 - 140.0
M	140.1 - 170.0
N	170.1 - 200.0
P	200.1 - 225.0
R	225.1 - 245.0
S	245.1 - 270.0
T	270.1 +

TN: 98-001
SUPERCEDES: 97-01

HCFA
APPROVAL:

APR 01 2001

EFFECTIVE: 2/1/98
REVISION: 2/9/01

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State Plan Under Title XIX of the Social
Security Act

State: Massachusetts

Institutional Reimbursement

APPENDIX C

M.G.L. c. 111 §72N

Action to Appoint Receiver;
Hearing;
List of Persons;
Purpose of Receivership;
Stay of Actions

TN: 98-001
SUPERCEDES: 97-01

HCFA
APPROVAL: APR 04 2001
EFFECTIVE: 2/1/98
REVISION: 2/9/01

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cannot be adequately assured pending the full hearing and decision on the matter. 11
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As used in this section "emergency" shall mean a situation or condition which presents imminent danger of death or serious physical harm to patients, including but not limited to imminent or actual abandonment of an occupied facility, and excluding a crisis due solely to a natural disaster beyond the control of the licensee where the licensee is taking appropriate remedial steps. An organized labor activity conducted for union recognition or as a tactic in contract negotiations shall not, of itself, constitute an emergency. Voluntary withdrawal from participation as a provider of services under the medical care and assistance program, established under chapter one hundred and eighteen E, or under the program of health insurance for the aged and disabled established under Title XVIII of the Social Security Act (P.L. -89-97) where such withdrawal was not occasioned by the denial of certification to the facility, shall not, of itself, constitute an emergency. 13
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111:72N. Action to appoint receiver; hearing; list of persons; purpose of receivership; stay of actions.

Section 72N. The department or the attorney general may bring an action in the superior court department of the trial court requesting the appointment of a receiver to operate a facility. Before the department brings such an action, a nursing home administrator designated by the commissioner shall be informed that the department intends to bring such an action and shall be informed of the reasons for the decision to bring such an action. Said administrator shall be duly licensed according to the provisions of section one hundred and eleven of chapter one hundred and twelve of the General Laws and shall have at least five years experience as a nursing home administrator. Said administrator may submit his recommendations concerning the facility proposed for receivership within two business days after receiving the above information. After said two-day period, the department, in its sole discretion may bring an action in the superior court department described in this section. A resident or guardian of a resident may petition the department or the attorney general to seek a receivership under this section. If the department or attorney general denies such petition or fails to commence action within five days, the party bringing the petition may bring suit in the superior court department for the appointment of a receiver or other appropriate relief under this section. Upon filing of this suit, a resident or guardian shall serve a copy of the complaint on the department. Prior to any hearing for the appointment of a receiver, the department shall file, and the court shall consider, an affidavit made under oath describing the results of any investigation conducted by the department, including a statement of any findings with respect to the resident's petition and the reasons for not filing an action pursuant to this section, and shall append thereto the two most recent reports of 1
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deficiencies in that facility. Nothing in this chapter shall be construed as abrogating or superseding any common law or statutory right of any person to bring an action requesting appointment of a receiver to operate a facility. 28
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The department may, in its sole discretion, in addition to or in lieu of bringing an action hereunder, assist a licensee in seeking a rate adjustment or other relief from the rate setting commission. 32
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The court shall issue a short order of notice and, where an emergency is alleged, set the matter for hearing within five days after filing of the action. In all other cases, a hearing shall be set within two weeks. A receiver shall be appointed immediately, on an ex parte basis, if it appears by verified complaint or by affidavit that there are grounds for the appointment of a receiver and that immediate appointment is necessary to prevent harm to the residents. 35
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The court may appoint as a receiver any person appearing on a list established for the purpose by the commissioner and the secretary of elder affairs after consultation with representatives of the nursing home industry. Persons appearing on said list shall have experience in the delivery of health care services, and, if feasible, shall have experience with the operation of long term care facilities. 42
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The purpose of a receivership created under this section shall be to safeguard the health, safety and continuity of care to residents and to protect them from the adverse health effects and increased risk of death caused by abrupt or unsuitable transfer. A receiver appointed hereunder shall not take any actions or assume any responsibilities inconsistent with this purpose. 48
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No person shall impede the operation of a receivership created under this section. There shall be an automatic stay for a sixty-day period subsequent to the appointment of a receiver, of any action that would interfere with the functioning of the facility, including but not limited to cancellation of insurance policies executed by the licensee, termination of utility services, attachments or set-offs of resident trust funds and working capital accounts, and repossession of equipment used in the facility. 54
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111:72O. Authority of receiver; duties; closure of facility; repairs; financial assistance.

Section 72O. When a receiver is appointed, the licensee shall be divested of possession and control of the facility in favor of the receiver. With the approval of the court, the receiver shall have authority to remedy violations of federal and state law and regulations governing the operation of the facility; to hire, direct, manage and discharge any consultant or employees, including the administrator of the facility; to receive and expend in a reasonable and prudent manner the revenues of 1
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State Plan Under Title XIX of the Social
Security Act

State: Massachusetts

Institutional Reimbursement

APPENDIX D

M.G.L. c. 118E §13

Rates;
Approval;
Review

TN: 98-001
SUPERCEDES: 97-01

HCFA APPROVAL: APR 04 2001 EFFECTIVE: 2/1/98
REVISION: 2/9/01

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Any provider who violates the provisions of this section by failing to provide care to a medical assistance recipient residing in its facility shall be subject to a fine of one thousand dollars for each violation.

As a method of providing medical assistance to recipients, the division is authorized to contract with any fiscal agent, institution, health insurer, health maintenance organization, health plan, management service or consultant firm consistent with the requirements of 42 CFR Part 434 to administer all or part of the services and benefits available under this chapter; or, to establish a health maintenance organization; provided, that said health maintenance organization shall be operated in accordance with applicable federal and state law.

118E:13. Rates; approval; review.

Section 13. The commissioner shall review, and approve or disapprove, any change in Title XIX rates or Title XIX rate methodology proposed by the division of health care finance and policy established by chapter one hundred and eighteen G, which shall be called the "division" only for purposes of this section. The commissioner shall review such proposed rate changes for consistency with agency policy and federal requirements, and within the level of funding available as authorized by the general appropriation act prior to the certification of such rates by the division; provided, that the commissioner shall not disapprove a rate increase solely based on the availability of funding if the federal health care financing administration provides written documentation that federal reimbursement would be denied as a result of said disapproval and said documentation is submitted to the house and senate committees on ways and means. The commissioner shall, when disapproving a rate increase, submit the reasons for disapproval to the division together with any recommendations for changes. Such disapproval and recommendations, if any, shall be submitted after the commissioner is notified that the division intends to propose a rate increase for any class of provider under Title XIX; but in no event later than the date of the public hearing held by the division regarding such rate change; provided, that no rates shall take effect without the approval of the commissioner. The division and the commissioner shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the house and senate committees on ways and means. The division shall supply the commissioner with all statistical information necessary to carry out his duties under this section. Notwithstanding the foregoing, the commissioner shall not review, approve, or disapprove any such rate set pursuant to chapter twenty-three of the acts of nineteen hundred and eighty-eight. If projected payments from rates necessary to conform to applicable requirements of Title XIX are estimated by the commissioner to exceed the amount of funding appropriated for such purpose in the general appropriation act in any fiscal year, the division and the commissioner

shall jointly prepare and submit to the Governor a proposal for the
minimum amount of supplemental funding necessary to satisfy the
requirements of the under Title XIX state plan.

118E:13A. Non-acute hospitals; rates and terms of payment.

Section 13A. For hospital fiscal years beginning on or after October
first, nineteen hundred and ninety-seven, rates and terms of payment
established by the division with non-acute hospitals for services rendered
to patients entitled to medical assistance under this chapter shall be
established by contract between the division and such hospitals, unless
otherwise required by law. Prior to said October first, for those non-
acute hospitals whose rates and terms of payment have not been
established by contract with the division, said rates and terms of
payment shall be based on the system of reimbursement in effect
immediately prior to the effective date of this section. This section shall
not be construed preventing said division and a non-acute hospital from
agreeing to such a contract prior to such date. Any medical necessity
and administratively necessary determinations the division may establish
for non-acute hospitals shall be based on the screening criteria and
procedures applied by peer review organizations as are duly authorized
under the Social Security Act.

For any hospital fiscal year subsequent to nineteen hundred and
ninety-eight, the division of medical assistance may elect, solely at its
discretion, that public payor-dependent non-acute hospitals shall be
subject to the provisions of the preceding paragraph; provided, that
reimbursement so established by said section shall include an adminis-
tratively necessary day adjustment for any patient that a public payor-
dependent non-acute hospital is unable to place in a more appropriate
facility based on said screening criteria and procedures; provided fur-
ther that the terms of payment for any such patient shall reflect the
reasonable costs of any such hospital in providing care to recipients of
medical care and assistance; and provided further, that reimbursement
so established shall reflect the reasonable costs of treating a dispropor-
tionate share of public payor patients.

118E:14. Nursing home negotiated rate contracts.

Section 14. Pursuant to the second paragraph of section twelve, the
division shall enter into negotiated rate contracts with nursing homes
that recognize the acquisition cost, or portion thereof which exceeds the
allowable basis under relevant regulations of the rate setting commis-
sion, as the allowable basis of fixed assets where there has been a change
of ownership effective on or after January first, nineteen hundred and
eighty-seven, provided that: